

A REVIEW OF THE LONG-TERM EFFECTS OF CHILD SEXUAL ABUSE

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Abstract—The existing literature on the long-term sequelae of child sexual abuse is reviewed. The evidence suggests that sexual abuse is an important problem with serious long-term sequelae; but the specific effects of sexual abuse, independent of force, threat of force, or such family variables as parental psychopathology, are still to be clarified. Adult women with a history of childhood sexual abuse show greater evidence of sexual disturbance or dysfunction, homosexual experiences in adolescence or adulthood, depression, and are more likely than nonabused women to be revictimized. Anxiety, fear, and suicidal ideas and behavior have also been associated with a history of childhood sexual abuse but force and threat of force may be a necessary concomitant. As yet, there is insufficient evidence to confirm a relation between a history of childhood sexual abuse and a postsexual abuse syndrome and multiple or borderline personality disorder. Male victims of child sexual abuse show disturbed adult sexual functioning. The relation between age of onset of abuse and outcome is still equivocal. Greater long-term harm is associated with abuse

This paper is a revised version of a final report submitted to Health and Welfare Canada (Grant No. 6606-3440-CSA).

Received for publication October 16, 1989; final revision received April 19, 1990; accepted July 2, 1990.

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involving a father or stepfather and abuse involving penetration. Longer duration is associated with greater impact, and the use of force or threat of force is associated with greater harm.

Key Words—Sexual abuse in childhood, Long-term effects.

INTRODUCTION

THE INITIAL and short-term effects of child sexual abuse (CSA) have been reviewed elsewhere (Beitchman, Zucker, Hood, daCosta, & Akman, 1991; Browne & Finkelhor, 1986). Although various symptoms have been reported to occur in the early aftermath of child sexual abuse, ambiguity exists as to which effects may be directly attributed to the abuse and which may be related to other antecedent or concomitant variables. Also, there may be “sleeping” effects, of which the child and others are unaware, but which emerge with dramatic impact in adulthood. For example, sexual dysfunction may not be evident as a short-term consequence of sexual abuse in the prepubertal child. In adults, however, healthy sexual functioning is considered to be an important component of adjustment. It should be recognized, then, that long-term effects of sexual abuse may manifest differently from short-term effects. Because an adult is able to assess childhood events from a different psychological perspective than the child, understanding the adult perspective is necessary to unravel the full impact of CSA. This is not to suggest that short-term effects are to be minimized in favor of long-term effects since suffering and disturbance at any age call for a therapeutic response; however, a clearer understanding of both the short- and long-term effects of child sexual abuse may be helpful in planning treatment and in directing the allocation of scarce resources.

Since Browne and Finkelhor's (1986) review of the literature on the short- and long-term effects of child sexual abuse, there have been several new publications which extend their findings and also suggest possible revisions to some of their conclusions. In addition, some issues, such as multiple personality disorder, not included in their discussion, are critically examined here. Part I of this review evaluates research related to adult clinical symptomatology associated with childhood sexual abuse. Part II deals with the relation between abuse-specific variables and long-term outcome. Data for this review were taken from clinic-referred samples and nonclinic samples. Clinic samples refer to individuals who have attended some type of mental health setting for the assessment or treatment of sexual abuse or for the immediate or long-term sequelae of sexual abuse. Some samples contained patients who were referred because of various psychiatric or psychological symptoms, whose history of abuse was only discovered later. In these clinical settings the psychiatric symptoms would naturally be common among the subject sample. As is usual with clinical samples, a constellation of variables commonly associated with psychopathology, such as family disruption, parental illness, alcoholism, etc., was also found in these clinical populations so that their unique relation to CSA could not easily be determined unless a control group was included. Unfortunately, control groups were rarely employed in these studies of clinical samples.

Nonclinical samples may consist of random representative surveys. There may be quota surveys, in which a defined number of people in a particular locale or representing a specific group are surveyed (e.g., patrons at a bar). Subjects may volunteer as study participants to obtain credit for courses; volunteers may be solicited from newspapers or from advertisements. Each of these nonclinical samples, except the random representative survey, reflects biases in the way the samples were obtained, thereby limiting the generalizations permitted. The true prevalence of a given condition can only be obtained from a random, representative sample. The prevalence in clinical samples of nonrandom representative samples can be higher or lower than the true rate depending on which specific group is sampled. Selecting volunteers from a university course on sexuality may result in a higher prevalence of CSA

than the true rate. If individuals with a history of CSA choose courses on sexuality because of their own history of abuse, this would inflate the prevalence of CSA above the true prevalence and could lead to erroneous conclusions (e.g., CSA is more common among college students than the general public). It may also lead to false assumptions about which variables are associated with CSA (e.g., that college education is associated with CSA). Consequently, one must be cautious about interpreting the results of studies of clinical and other nonrandom representative samples without adequate control groups. Sample and design characteristics of the studies reviewed are presented in Table 1.

ADULT SYMPTOMATOLOGY ASSOCIATED WITH CHILD SEXUAL ABUSE (CSA)

Sexual Disturbance

To assume that CSA results in some form of adult sexual disturbance or dysfunction is intuitively reasonable. Since sexualized behavior is one of the few short-term effects that is consistently associated with CSA, and if continuity between short-term effects and long-term effects exists, disturbance in this domain should be evident in adulthood. This has indeed been reported in studies of clinical samples of CSA victims (Browne & Finkelhor, 1986). For example, Meiselman (1978) found that 87% of 23 CSA victims reported being frigid, confused about their sexual orientation, or promiscuous. Briere (1984) noted that 40% of the CSA victims in his sample reported problems of sexual adjustment, but Briere simply recorded the number of women reporting decreased sex drive without defining it further. Several other studies, using mixed samples of clinical and nonclinical subjects, also reported significant differences between those sexually abused vs. those not abused on measures of sexual dissatisfaction (Finkelhor, 1979; Gold, 1986; Tsai, Feldman-Summers, & Edgar, 1979). Only Fromuth's (1986) study with college students was equivocal, showing a weak relation between CSA and later sexual behavior. Brunngraber (1986) did not have a comparison group, but noted that a majority of her subjects reported sexual disturbance.

The Los Angeles Epidemiologic Catchment Area (ECA) report by Stein, Golding, Siegel, Burnam, and Sorenson (1988) is the only study based on a random representative sample to have examined the prevalence of adult sexual dissatisfaction or disturbance in CSA victims. Based on a probability sample of 3,132 men and women (18 or older), the study investigated the long-term psychological sequelae of CSA. Excluding women who had been sexually abused as adults, 20% of the 51 women with a history of CSA reported one or more symptoms of sexual disturbance within the previous six months. The lifetime prevalence of specific sexual disturbance reported by these women indicated that 36% had fear of sex, 32% had less sexual interest, and 36% had less sexual pleasure; unfortunately, the percent of women with no history of CSA who reported symptoms of sexual disturbance was not provided. Nor was information provided on the type of abuse sustained by these women or whether other forms of sexual disturbance, such as promiscuity or confused sexual orientation, were present. In addition, in another study of 100 "normal" couples (Frank, Anderson, & Rubenstein, 1978), 21% of women and 33% of men complained of sexual dissatisfaction, suggesting that the base rate of sexual problems in the general population is high.

Thus, the "excess" proportion of sexual disturbance found in a general population that can be attributed to a prior history of CSA remains unknown. Furthermore, because various definitions of sexual disturbance have been used and each one resulted in a different rate, it is essential that sexual disturbance be explicitly and precisely defined. In view of the high base rate of sexual dissatisfaction, an appropriately matched control group is necessary; otherwise,

Table 1. Studies of Effects of Child Sexual Abuse

Study	Source of Victim Sample	Total N	Victims	Non victims	Age Group	Intra/Extra familial	Comparison Group(s)	Outcome Measure(s)
Alexander & Lupfer (1987)	University undergraduates	586	149 F	437 F	A	I, E	NC	SR, ST
Bagley & Ramsay (1986)	Community sample	377	82 F	295 F	A	I, E	NC	SR
Barnard & Hirsch (1985)	Psychiatric patients	30	30	—	ND	I, E	—	CR
Becker (1988)	Sexual behavior clinic	139	27 M	112 M	Ad	I, E	PC	SR
Briere (1984)	Community counselling service	153	67 F	86 F	A	I, E	PC	SR
Briere & Runtz (1986)	Crisis counselling program	195	133 F	62 F	A	I, E	PC	SR
Brunngraber (1986)	Public advertising	21	21 F	—	A	I	—	VI
Bryer, Nelson, Miller, & Krol (1987)	Psychiatric patients	66	36 F	30 F	A	I, E	PC	CR, ST
Conte & Schuerman (1987)	Sexual assault centre	687	85 M 284 F	134 M 184 F	C, Ad	I, E	NC	VI, PI
Courtois (1979)	Public advertising	31	31 F	—	A	I	—	VI
Finkelhor (1979)	University students	796	23 M 102 F	243 M 428 F	A	I, E	NC	SR
Fromuth (1986)	College psychology classes	383	84 F	299 F	A	I, E	NC	SR, ST
Gold (1986)	Advertising, clinics, psychology classes	191	103 F	88 F	A	I, E	NC	ST
Gorcey, Santiago, & McCall-Perez (1986)	Advertising, mental health agencies	97	41 F	56 F	A	I, E	PC	VI
Gundlach (1977)	Community sample	458	115 F	343 F	A	I, E	NC	SR
Herman, Russell, & Trocki (1986)	Community sample, therapy groups	205	205 F	—	A	I	—	SR
Herman & Schatzow (1987)	Outpatient therapy patients	53	53 F	—	Ad, A	I	—	VI
Johnson & Shrier (1985)	Hospital outpatient department	80	40 M	40 M	Ad, A	I, E	NC	VI
Langmade (1983)	Clinical sample	68	34 F	34 F	A	I	PC	SR, ST
Longo (1982)	Convicted sexual offenders	17	13 M	4 M	Ad	—	O	SR
Meiselman (1978)	Psychiatric clinic	158	47 F 11 M	50 F 50 M	Ad, A	I	PC	VI, CR
Mullen, Romans-Clarkson, Walton, & Herbison (1988)	Community survey	314	41 SA-F 63 PA-F	210	A	I, E	NC, O	ST
Murphy, et al. (1988)	Community sample	391	38 F	353 F	A	I, E	NC, O	ST, SR
Peters (1985)	Community sample	119	71 F	48 F	A	I, E	NC	ST
Runtz (1987)	University undergraduates	291	73 F	218 F	A	I, E	NC	SR, ST
Runtz & Briere (1986)	University undergraduates	152	41 F	111 F	Ad, A	I, E	NC	SR
Russell (1986)	Community sample	930	152 F	778 F	A	I	NC	VI, SR
Sedney & Brooks (1984)	College students	301	48 F	253 F	A	I, E	NC	SR
Seidner, Calhoun, & Kilpatrick (1985)	Psychology undergraduates	152	17 M 59 F	17 M 59 F	A	I, E	NC	SR, ST
Silbert & Pines (1981)	Former and current prostitutes	200	120 F	80 F	Ad, A	I, E	O	SR
Stein et al. (1988)	Community sample	3,128	179 M 348 F	1,294 M 1,307 F	A	I, E	NC, O	SR
Tsai, Feldman-Summers, & Edgar (1979)	Therapy patients, advertising	90	60 F	30 F	A	I, E	NC	SR, ST

M = Male; F = Female; C = Child; Ad = Adolescent; A = Adult; I = Intrafamilial; E = Extrafamilial; NC = Normal Control; PC = Psychiatric Control; O = Other Comparison Group; SA = Sexual Abuse; PA = Physical Abuse; CR = Chart Review; PI = Parent Report/Interview; SR = Self-Report; ST = Standardized Test(s); VI = Victim Interview; ND = No Data.

one cannot ascertain whether the rates of sexual disturbance are due to a history of CSA or to other factors.

Despite these concerns, some general conclusions on the long-term effects of CSA on adult sexual functioning can be made. The highest rates of sexual disturbance were found in studies examining father-daughter incest (Herman, 1981; Meiselman, 1978) or abuse involving penetration (Brunngraber, 1986). In studies where the proportion of women victimized by their fathers was small (Finkelhor, 1979) or where the type of abuse rarely included intercourse or oral-genital contact, sexual dysfunction was either ambiguously linked to CSA (Fromuth, 1986) or the effects were weak (Finkelhor, 1979). Finally, higher rates of sexual dysfunction are typically found in clinical samples of adult women sexually abused in childhood. It is more likely that women seeking therapy were victims of CSA involving a father figure and/or intercourse or oral-genital contact. Thus, type of abuse is correlated (confounded) with help-seeking behavior.

Since attitudes towards sexuality develop over time and include a multitude of influences, moderating variables which may serve to increase or decrease the long-term impact of sexual abuse on the child's functioning may be important. Thus, sexual abuse is likely to exert its effect in the context of the child's other experiences. Some support for this view can be found in Gold's (1986) report that a woman's present perception of her abuse and of her mother's response to it best predicted adult functioning.

Homosexuality

There have been several reports showing a relation between a history of CSA and later homosexual behavior. Fromuth (1986), for instance, found a weak but significant relation between CSA and homosexual experiences ($r = .12$). Runtz and Briere (1986) reported a significantly higher incidence of homosexual contact among 39 sexually abused women compared with 11 nonabused controls. Meiselman (1978) found that 7 of 23 women abused by their fathers were lesbian or had significant conflicts about homosexual feelings, whereas homosexual behavior was rare in the control group. Herman (1981), however, reported that among 40 incest victims the vast majority of women were exclusively heterosexual. Herman noted that 2 of the 40 women developed a confirmed lesbian identity and 3 others considered themselves to be bisexual. A minimum of 5 out of 40 incest victims (12.5%) would appear to have been involved in homosexual activities—not an insubstantial number. No estimate is given by Herman of the number of women in the control group who had homosexual experiences. In a nationwide study, Gundlach (1977) found a significantly higher proportion of reported childhood rape or molestation among homosexual women, compared with a control group of heterosexual women. The only study that showed no association between homosexual activity and CSA (Bell, Weinberg, & Hammersmith, 1981) did not adequately define the nature of subjects' CSA experiences; thus, it is unclear what conclusions about the relation between homosexual behavior and CSA can be drawn from this study.

In conclusion, there may be a small but significant increased rate of homosexual activity among women who have been sexually abused in childhood. Only a small number of studies have examined this association, and the majority relied on clinical samples; consequently, these conclusions must be considered tentative but important enough to warrant further study. The question of homosexual behavior among men as a consequence of CSA will be discussed in the second part of this review.

Anxiety and Fear

There is some evidence that women with a history of CSA, compared with nonabused women, suffer from generalized emotional symptoms such as fear, anxiety, and depression. In

Briere's (1984) study, CSA victims were significantly more likely than nonabused controls to report fear of men, anxiety attacks, and problems with anger; however, 49% of his CSA subjects had also been battered in an adult relationship, and consequently whether these symptoms were related to the CSA, the recent physical abuse, or both is not clear. Fromuth (1986) reported that in a sample of 383 undergraduate women, phobic anxiety assessed by the Hopkin's Symptom Checklist (SCL-90) was the only symptom significantly associated with CSA after controlling for the effects of parental support (the relationship, however, was weak, with a squared semipartial correlation of only .01). In a study of psychotherapy patients, Herman and Schatzow (1987) found that of 53 women sexually abused as children, 14 (26%) had chronic severe anxiety. In the majority of cases, the abuse had been accompanied by force (23%) or the threat of force (38%), and 75% had been abused by a father or stepfather. Sedney and Brooks (1984) compared the symptoms of 51 college students reporting CSA with those of 51 control women. Anxiety was significantly more common among intrafamilial CSA victims than among controls. Yet, when the intrafamilial and extrafamilial abuse victims were considered together, anxiety did not differentiate them from controls. Anxiety was significantly associated with a history of intrafamilial but not extrafamilial abuse, compared with the nonabused controls. Using a community sample, Murphy et al. (1988) found significantly higher anxiety scores on the SCL-90 among child and adolescent sex abuse victims ($n = 86$) than among nonvictims ($n = 184$). Two-thirds of the victims had been subjected to force or the threat of force during the abuse. Gorcey, Santiago, and McCall-Perez (1986) found higher levels of anxiety and significantly higher scores on the Fear Survey Interview among CSA victims ($n = 41$) than among controls ($n = 56$). Stein et al. (1988) found a current prevalence of anxiety disorders of 28% among CSA victims ($n = 51$), compared with 9% of women not sexually abused ($n = 1,307$). The lifetime prevalence of anxiety disorders was 37% for CSA victims and 14% for controls.

Three of the seven studies that showed a positive relation between CSA and adult anxiety symptoms also reported that the use of force or threat of force had been common among CSA victims (Briere, 1984; Herman & Schatzow, 1987; Murphy et al., 1988). Gorcey et al. (1986) and Stein et al. (1988) did not provide information on the use of force, and Fromuth (1986), who found only a weak relationship between CSA and phobic anxiety, also did not report on the use of force. While anxiety symptoms among adult women appear to be associated with a history of CSA, it is not clear that this effect is independent of force or the threat of force at the time of the sexual abuse. This is an important variable which should be explored systematically in future studies.

Depression

Drawn from a community survey of 248 Los Angeles County women, 50 Afro-American and 69 white women participated in interviews requiring personal and family histories (Peters, 1988). Women with a history of contact CSA were significantly more likely than victims of noncontact abuse or nonabused controls to have experienced a major depressive episode and to have had more depressive episodes. History of abuse was unrelated to previous suicide attempts. The relation between CSA and depression was still significant after controlling for the influence of maternal warmth. The ECA study (Stein et al., 1988) found a significantly higher current prevalence of major depression among sexually abused women compared with controls (17% and 3%, respectively). Lifetime prevalence of major depression showed a similar pattern with 22% of CSA women vs. 6% of nonabused women. In a community survey in New Zealand, Mullen, Romans-Clarkson, Walton, and Herbison (1988) found that compared with nonabused controls, women reporting CSA were more frequently identified as requiring treatment, usually for depression.

In a sample of college women, Sedney and Brooks (1984) reported a significantly higher rate of depression and thoughts of self-harm among CSA victims than among controls. Gold (1986) found significantly more depression, as measured by the Beck Depression Inventory (BDI), and lower self-esteem among 103 women sexually abused in childhood than among 88 nonabused normal controls. Similarly, Gorcey et al. (1986) reported significantly higher levels of depression on the BDI among CSA victims compared with normal controls.

Fromuth (1986) failed to find a significant association between depression, as measured by the SCL-90, and a history of CSA. Depression was, however, correlated with the level of parental support present in the family. Murphy et al. (1988) did not find higher SCL-90 depression scores among CSA victims compared with nonvictims; however, women who had sustained multiple abuse experiences (i.e., prior to age 18 and a subsequent sexual assault at 18 or older) obtained significantly higher scores than all other groups of CSA victims (child, adolescent, or adult) and nonabused controls. Adult victims of sexual assault also had significantly higher depression scores than nonvictims.

Of the eight studies reviewed, six found an association between CSA and adult depressive symptoms, while two found no such association (Fromuth, 1986; Murphy et al. 1988). Fromuth's (1986) sample, however, included cases in which less severe forms of sexual abuse were common. The negative findings reported by Murphy et al. (1988) may have been due to the time that had elapsed between the last incident of abuse and testing. Indeed, the correlation between depression scores and time elapsed since sexual abuse was .16 ($p < .010$), and the average time since the assault was 37 years! The role of the child's family, especially the child's perception of the mother's response to the abuse and the degree of parental support, may be important mediating factors between CSA and depressive response in adulthood.

Suicide

Suicidality has also been associated with CSA (Briere & Runtz, 1986; Bryer, Nelson, Miller, & Krol, 1987). Among clients attending a crisis counseling center, Briere and Runtz (1986) found that 56% of women with a history of CSA ($n = 133$) compared with 23% of nonabused women ($n = 62$) had a history of previous suicide attempts. Within the sexual abuse group, current suicidality was associated with the total number of perpetrators and the presence of compound abuse (physical and sexual abuse), while the number of previous suicide attempts was related only to compound abuse. From these data, it is difficult to assess the relation between CSA and suicidality independent of physical abuse.

In a study of 66 private psychiatric inpatients, Bryer et al. (1987) found that women with a history of suicidal ideation, gestures, and/or attempts were three times more likely to have been abused in childhood than were inpatients without these symptoms. The authors, however, did not specify whether the women with suicidal histories had been sexually abused ($n = 14$), physically abused ($n = 12$), or whether they had experienced both types of abuse ($n = 22$). The results, therefore, do not permit any firm conclusions with respect to the relation between sexual abuse and later suicidal behavior.

Bagley and Ramsay (1986) reported that compared with nonabused controls ($n = 294$) CSA victims ($n = 83$) had significantly higher frequency of suicide plans and/or deliberate self-harm or suicide attempts (5% vs. 0%); however, this sample was a subset of an earlier multi-stage survey of suicidal backgrounds of a given population and may not have been representative of the sexually abused within the general population. In addition, 81% of the CSA victims acknowledged stress and adverse reactions in the previous six months, and one-third of the abuse experiences involved direct force or threat. It is hard, therefore, to distinguish between proximate effects and those more directly related to force, threat of force, or their childhood sexual victimization. Finally, Sedney and Brooks (1984) and Peters (1988) found no relation between a history of CSA and suicidality.

Overall, the evidence does not support a link between suicidality and CSA in the absence of force or threat of force. Suicidality, however, does appear to be related to concurrent physical and sexual abuse in childhood. The relation between physical abuse and suicidality is not known and merits further study.

Revictimization

Revictimization has also been associated with CSA (Alexander & Lupfer, 1987; Briere, 1984; Fromuth, 1986; Gorcey et al., 1986; Runtz, 1987; Russell, 1986). Briere found that 49% of his sexually abused sample had been victims of battering in an adult relationship, a rate almost three times greater than that of a psychiatric control group. Of the sexual abuse victims interviewed by Gorcey et al., 37% reported that they had been raped as teenagers or adults; and Russell found that 65% of the incest victims in her study compared with 36% of nonabused controls had been victims of subsequent rape or attempted rape. Runtz reported that 44% of women with a history of CSA were also victims of sexual assault as teenagers or young adults, compared with 20% of women with a history of physical abuse. Finally, Fromuth also found a significant association between a history of sexual abuse and later rape.

Although weak, this association remained significant even after partialling out the effect of parental support. Murphy et al. (1988) did not find an increased rate of revictimization among CSA victims. Indeed, 30% of controls, compared with 26% of CSA victims, had been revictimized at the age of 18 or older. Despite this finding, the majority of studies do report an increased risk of revictimization among those sexually abused as children.

Finkelhor (1979) suggested that the association between childhood sexual abuse and revictimization may be due to factors that force victimized children out of the family and into high-risk situations for wife abuse or rape. Childhood sexual abuse may also have a corrosive effect on self-esteem, therefore making these women conspicuous targets for sexually exploitative men. In a survey of former and current prostitutes, Silbert and Pines (1981) found that 60% of these women had been sexually abused prior to age 16. Herman (1981, p. 103) suggested that women who have been sexually abused as children may idealize men, seeking to recapture the specialness they had felt in the relationship with their father; and Runtz (1987) has proposed that a combination of idealization and oversexualization, together with an impaired ability to identify correctly persons who are untrustworthy, are critical factors in explaining revictimization. Personality variables, such as a sense of worthlessness and self-blame, may antedate, co-exist, or follow CSA, leading these women to expose themselves to men who revictimize them, and thus confirm their low opinion of themselves.

Postsexual Abuse Syndrome

Briere (1984) proposed that victims of CSA show a "postsexual abuse syndrome" characterized by symptoms of fear, periods of dissociation and withdrawal, problems with anger, chronic muscle tension, and self-injurious feelings. Since 49% of the women in his sample had been the victims of battering in an adult relationship, it is difficult to ascertain whether their symptoms were attributable to CSA or to more current problems. While other studies have also linked CSA to a variety of symptoms, anxiety and depression are the only ones consistently reported. For example, although Mullen et al. (1988) found that depressive, anxiety, and phobic symptoms characterized the clinical syndrome of abused women, they could not identify a pattern of symptoms that distinguished these women from others with depressive and anxiety disorders. The evidence available does not yet justify the designation of a postsexual abuse syndrome.

Personality Disorders

Several studies have reported a link between CSA and the development of multiple personality disorder (MPD) (Bliss, 1984; Coons & Milstein, 1986). Bliss found that 60% of female inpatients with MPD reported a history of child sexual abuse and 50% reported a history of physical abuse. Yet, only 20 of the 48 subjects in his sample met the DSM-III criteria for a diagnosis of MPD; the remaining 28 subjects were referred to as "possible multiples." Coons and Milstein compared 20 patients who met DSM-III criteria for MPD with 20 nonschizophrenic inpatients and found that 75% of the MPD patients compared with only 5% of the psychiatric controls had a positive history of CSA. Yet because 55% of the MPD patients also had a history of physical abuse, the independent effects of CSA are impossible to determine. Putnam, Post, and Guroff (1983) (cited in Coons & Milstein, 1986) studied a series of 100 MPD patients and found an 83% incidence of sexual abuse and a 75% incidence of physical abuse.

Although clinical reports support an association between MPD and a history of CSA, none of the studies reviewed validated diagnoses through independent raters, so that the possibility of bias and unreliability of diagnosis exists. A majority of the MPD patients also experienced physical abuse, again weakening any specific association between CSA and MPD. The report by Briere (1984) showing a higher prevalence of symptoms of "dissociation" among college students with a history of CSA, while suggestive, cannot be considered to be equivalent to a diagnosis of dissociative disorder. Briere devised a checklist to estimate the prevalence of dissociative symptoms. While useful and interesting, the validity of this checklist has not been corroborated, and the extent to which these items are symptoms of other disorders, such as schizophrenia or panic disorder, is not known. One must conclude, therefore, that there is insufficient evidence to establish a strong link between CSA and MPD. To shed new light on this subject, future studies should rely on standardized criteria for diagnosis and specify rates of CSA, with and without physical abuse, found among MPD patients and appropriately matched controls.

An association between CSA and adult symptomatology reflecting borderline personality disorder (BPD) has also been cited by several authors (Barnard & Hirsch, 1985; Bryer et al., 1987; Herman & Schatzow, 1987). Barnard and Hirsch, for example, reported that 57% of the 30 incest victims in their study received a primary diagnosis of BPD; and Bryer et al. found that among 14 patients with BPD, 12 (86%) were victims of early sexual abuse.

The diagnosis of BPD and its differentiation from other personality disorders is subject to wide variability depending on the specific theoretical notion one has about the diagnosis (Dahl, 1985). Indeed, there is concern that BPD may be overdiagnosed (Kolb & Gunderson, 1980). The studies cited here provided no standardized diagnostic process or reliability data, so that the possibility of bias and of variabilities in the type of patient diagnosed as borderline is high. In addition, a disturbed relationship between the child and parents, characteristic of the borderline syndrome, may be more significant than the sexual abuse per se. At this time, a link between BPD and CSA remains to be established.

THE IMPACT OF ABUSE-SPECIFIC VARIABLES

Outcome in a variety of domains is usually examined when assessing the long-term impact of CSA. The areas of functioning assessed may be broad or narrow and may overlap. In some instances, the outcome measure of interest may be a diagnostic entity or syndrome (Stein et al., 1988), while in others it may be specific symptoms such as anxiety or fear (Briere, 1984).

Furthermore, some studies use broader measures of outcome, such as self-reports of degree of trauma sustained. While each of these approaches has merit, comparing findings across studies when outcome measures vary in their degree of specificity is difficult. For example, self-reported trauma can mean heightened anxiety, decreased self-confidence, feelings of depression, or none of these.

The causal links underlying observed symptomatology are not necessarily equivalent. Depression and low self-esteem may be more closely tied to an attributional style centered on feelings of guilt and self-blame, while fear and anxiety may result from exposure to force and violence. A meaningful understanding of the connections between abuse-specific variables and outcome requires clear specification of the variables measured, since various aspects of the abuse experience may differentially influence outcome. The second part of this review will consider findings related to the abuse-specific variables and, where possible, their impact on particular outcome domains.

Age at Onset of Abuse

Browne and Finkelhor (1986) found little clear relation between age of onset and trauma; but if a trend could be discerned, it was that younger age was associated with greater trauma. They cited studies by Meiselman (1978) and Courtois (1979) as reporting greater trauma from prepubertal than postpubertal abuse; unfortunately, there are important deficiencies in these studies which cast doubt on their conclusions. For example, in Meiselman's report, it is not clear how many girls were prepubertal at the time of onset of abuse or what age was used to define the onset of puberty. Courtois' report is also difficult to evaluate since no information was given about the ages of the victims or the type of abuse sustained. The overall effect of prepubertal vs. postpubertal abuse was not significant. Of the 30 subjects, 16 were in therapy, and this may have been a confound since significant differences in outcome measures were found between the therapy and no therapy groups. The remaining studies cited by Browne and Finkelhor (1986) reported no significant association between age of onset of abuse and trauma (Finkelhor, 1979; Langmade, 1983; Russell, 1986). Bagley and Ramsay (1986) reported a significant association between early age of onset and later trauma; but after controlling for penetration, abuse involving the effect of age was no longer significant. Two other studies reported an association between postpubertal onset and greater impact. Sedney and Brooks (1984) found postpubertal abuse to be associated with more self-reported symptomatology than prepubertal abuse. Murphy et al. (1988) found that adolescent sex abuse victims showed a wider variety of symptoms than those children abused prior to adolescence.

There is somewhat better evidence of a greater effect of postpubertal abuse than prepubertal abuse; however, because age of onset is correlated with several other abuse-specific variables, an independent assessment of this variable is difficult. For instance, older children and adolescents are more likely than younger children to be subjected to invasive abuse (Gomes-Schwartz, Horowitz, & Sauzier, 1985; Murphy et al., 1988; Peters, 1976); however, younger children are more likely than older children to be abused by a father or stepfather, which has been reported to result in greater trauma than abuse by other perpetrators (Finkelhor, 1979; Herman, Russell, & Trocki, 1986; Russell, 1986). In addition, age of onset may be correlated with the duration of the abuse, which is again associated with greater trauma. Consequently when the effects of age are being assessed, these associated variables must be controlled. Furthermore, when age of onset of abuse is examined, the age at which the abuse terminated must also be controlled for, since abuse beginning and ending prepubertally is not equivalent to abuse beginning prepubertally but ending postpubertally.

Sex of the Victim

Since the victims of sexual abuse are predominantly female (Farber, Showers, Johnson, Joseph, & Oshins, 1984; Finkelhor & Browne, 1985), little attention has been focused on male victims. Nonetheless, there is some evidence that the long-term impact of sexual abuse may be related to the sex of the victim. In a survey of 76 psychology undergraduates with a history of childhood sexual experiences, 65% of the male subjects ($n = 17$) reported poor social adjustment vs. 44% of the female subjects ($n = 59$) (Seidner, Calhoun, & Kilpatrick, 1985). Pierce and Pierce (1985) found that force or threat of force were significantly more common among male victims of CSA than among females. Johnson and Shrier (1985) found that 25% of victimized males ($n = 40$) compared with 5% of controls ($n = 40$) reported sexual dysfunction, and 60% said that the sexual abuse had had a significant impact on their lives. Finkelhor (1979) reported that males who had been victimized prior to age 13 by an older person ($n = 9$) were four times more likely than nonabused controls ($n = 243$) to be currently homosexually active. Rogers and Terry (1984) reported that male sex abuse victims showed confusion of sexual identity, inappropriate attempts to reassert their masculinity, and recapitulation of the abuse experience. Longo (1982) found in a sample of male adolescent sex offenders ($n = 17$) that 47% had been sexually abused as children, and Becker (1988) reported a 19% incidence of CSA among adolescent sex offenders ($n = 139$).

Based on these findings, the conclusion that there is evidence to support long-term sequelae of CSA among boys seems reasonable. Some of the outcome domains examined include sexual dysfunction, gender identity conflict, homosexuality, and an increased risk of becoming sex abuse perpetrators. While the evidence is suggestive and certainly warrants further research, there is an insufficient number of controlled studies from which to draw any firm conclusions. Whether male victims of CSA are likely to show more severe sequelae than female victims is a moot point. Only one study addressed sex differences in outcome (Seidner et al., 1985); although the results suggested a greater impact on males, several other factors must be controlled for before clear inferences can be drawn. Male and female subjects need to be matched for type of abuse, use of force or violence, frequency and duration of abuse, and relationship to the perpetrator before a clear statement can be made on the different outcomes of sexually abused boys and girls.

Relationship to Offender

Although intrafamilial abuse (excluding the father or stepfather) has not been shown to be more traumatic than extrafamilial abuse (Browne & Finkelhor, 1986), there appears to be a consensus that incestuous experiences involving a father or stepfather are more traumatic than abuse by other family members or by outsiders (Browne & Finkelhor, 1986; Russell, 1986). In Finkelhor's (1979) survey of 796 undergraduates, father-daughter incest was rated as most traumatic. Herman et al. (1986) also found father or stepfather-daughter incest to have more long-lasting effects. In the study by Tsai et al. (1979), those women with the worst outcomes were more likely to have been abused by fathers or stepfathers.

Abuse perpetrated by a father-figure is likely to be more traumatic than abuse by others for several reasons. Abuse by a parent involves greater betrayal and loss of trust than abuse by others. It may also reflect a significant level of family disturbance along with less available emotional support to the child. There may also be a variety of other severe consequences, such as open conflict, family break-up, and at times an unwillingness to believe the child. It is also probable that abuse by a parent occurs over a longer period of time and with greater frequency than abuse by others (Russell, 1986).

Some reports suggest that abuse by a father or stepfather is more likely to be associated with

adult sexual dissatisfaction or dysfunction (Finkelhor, 1979; Gold, 1986; Tsai et al., 1979). The impact of father-daughter incest on other outcome domains such as anxiety, depression, self-blame and guilt, and personality disorders will be important if we are to more fully understand the consequences of child sexual abuse.

Duration and Frequency of Abuse

Browne and Finkelhor (1986) concluded that available studies reached contradictory conclusions about the relation between duration of abuse and subsequent traumas. Russell (1986), Tsai et al. (1979), and Bagley and Ramsay (1986) were all cited in support of an association between longer duration and greater trauma. Three studies reported no association (Finkelhor, 1979; Friedrich, Urquiza, & Beilke, 1986; Tufts New England Medical Center, Division of Child Psychiatry, 1984), but only Finkelhor assessed the long-term impact of duration. The other two studies examined short-term effects. Two studies (Courtois, 1979; Seidner et al., 1985), which showed a negative relation, are difficult to assess. In Courtois' study, duration of abuse was dichotomized into less than six months and greater than six months; however, frequency of abuse within each duration category may have varied from abuse occurring daily or several times a week to one or two episodes of abuse. Seidner et al. reported high self-acceptance and low social maturity scores on the California Psychological Inventory. High self-acceptance and low social maturity appear to be contradictory, and the meaning of this result is unclear.

There have been two reports since Browne and Finkelhor's (1986) review that bear on the question of duration and its impact on outcome. Herman et al. (1986) found abuse lasting for more than two years to be more common among incest victims seeking psychotherapy ($n = 27$) than among those not seeking psychotherapy ($n = 29$; 51% vs. 19%, respectively). In addition, they found a rating of "lasting harm" to be associated with abuse of longer duration. In contrast, Mullen et al. (1988) reported greater psychopathology among women who had experienced solitary rather than repeated abuse. The authors believed that this result may have been due to bias introduced by the high scores obtained by women raped as adults.

Several points must be considered in trying to disentangle the available literature. First, the term "trauma" must itself be given close scrutiny. It does not follow that trauma is the same as "negative experience," a term used in Finkelhor's (1979) study. Its relationship with self-acceptance and social maturity scores of the California Psychological Inventory are similarly obscure. Is "lasting harm," as used by Herman et al. (1986), or psychopathology, as used by Mullen et al. (1988), equivalent to trauma, as used by Browne and Finkelhor (1986)? While there may be overlap in the meaning of these terms, some (or perhaps many) of the contradictory results noted above can be attributed to the problems of defining precisely the outcome of interest.

Second, there is evidence that force and violence are associated with more severe outcome. The report by Mullen et al. (1988) supports this finding and suggests, as well, that solitary violent sexual assaults are associated with high ratings of psychopathology. Repeated episodes of long duration of violent sexual assault are likely to be uncommon. Consequently, in assessing the long-term impact of duration, the degree of force or violence must be controlled.

Third, studies show that abuse by a father or stepfather is associated with greater long-term harm (Finkelhor, 1979; Russell, 1986). Further, stepfathers are more likely to use force or threats of force than are fathers, and abuse by stepfathers is more likely to include penetration than abuse by fathers (Russell, 1986). Since abuse by fathers or stepfathers is more likely to be of longer duration than abuse by nonrelatives, evaluating the effects of duration only makes sense if equivalent conditions are considered and equivalent outcomes are measured.

The available evidence suggests that solitary violent sexual assaults are associated with high

levels of psychopathological symptoms; but that, controlling for these effects of force or threat of force, abuse of long duration is also associated with "trauma" or "lasting harm." More subtle effects, such as self-blame and depression, may be more closely related to abuse of longer duration. These issues are worthy of further inquiry. In addition, studies are needed to clarify more precisely the relation between the independent effects of duration and a variety of outcome measures, such as trauma, anxiety, and depression.

Force

Force is one of the few abuse-specific variables for which agreement exists as to its long-term impact. A series of reports have been consistent in finding force or the threat of force as a strong predictor of outcome. Finkelhor (1979) reported that the use of force explained more variance in victims' negative reactions than any other predictor variable. Fromuth (1986) obtained similar findings, and Russell (1986) found a significant association between the use of force and violence and the degree of trauma reported. In her study, extreme or considerable trauma was reported by 100% ($n = 7$) who experienced violent abuse, by 74% ($n = 57$) who experienced forceful abuse, and by 46% ($n = 57$) who had experienced nonforceful abuse. Seidner et al. (1985) also found abuse experiences involving force to be associated with poorer levels of adjustment in adulthood. Herman et al. (1986) reported that perceptions of lasting harm were associated with experiences that were forceful or violent. The impact of these experiences manifested themselves in negative feelings about men, sex, or self, and personalized feelings of anxiety.

Seidner and Calhoun (1984) reported force to be associated with lower social maturity and higher self-acceptance, but the relation of these variables to other outcome measures, such as self-reported trauma or lasting harm is obscure. The majority of studies reviewed substantiate an association between force and negative outcome, which seems to be one of the more reliable findings.

Despite the strength of the relation between force and negative outcome, the specific nature of the long-term effects of force remains elusive. One would anticipate less self-blame and perhaps, as a consequence, less depression among those forced into a sexually abusive experience. Feelings of anxiety, fear, and a sense of trauma would more likely result from those victims of forceful abuse. One must also consider that force or the threat of force may interact with sexual abuse to produce effects (e.g., MPD, suicidality) that are unique to this combination or that are rare in the presence of either experience alone. These specific questions have not been considered as yet and may be promising research issues.

Penetration or Invasiveness

Sexual abuse involving penetration, such as intercourse or oral-genital contact, is usually thought to be more traumatic than abuse not involving penetration. Browne and Finkelhor (1986) cited a number of studies (Bagley & Ramsay, 1986; Landis, 1956; Peters 1988; Russell, 1986; Seidner & Calhoun, 1984; Tufts New England Medical Center, Division of Child Psychiatry, 1984) in support of an association between type of abuse sustained and trauma. They also noted three studies which did not show any consistent relation between type of sexual activity and long-term effects, concluding that there is disagreement about whether intercourse and penetration are demonstrably more serious than less invasive forms of abuse.

In order to adequately assess this issue, various types of abuse must occur sufficiently frequently so that their impact can be measured. For example, in Russell's (1986) survey, 43 women (24%) had experienced very severe sexual abuse involving penetration or attempted penetration, 76 (41%) were subjected to severe sexual abuse involving genital contact or simulated intercourse, and 67 (36%) experienced the least severe sexual abuse involving sex-

ual kissing and sexual touching of buttocks, thighs or clothed genitals. In contrast, in Finkelhor's (1979) sample, only 5 women (4%) had experienced abuse involving intercourse. Fromuth (1986) reported that abuse involving intercourse or oral-genital contact had been rare. No information is provided by these authors of the trauma ratings or some similar rating by these women who had been subjected to abuse by intercourse; however, it appears that abuse involving intercourse was too infrequent to properly assess its overall impact among the women studied by Fromuth and by Finkelhor.

Three additional studies not reported in Browne and Finkelhor's (1986) publication are relevant. Sedney and Brooks (1984) reported poorer adjustment in adulthood was associated with more invasive acts. Herman et al. (1986) noted that 11% ($n = 43$) of subjects' perceptions of "lasting harm" were associated with sexual activity that involved a high degree of physical violation (vaginal, anal, or oral penetration). Mullen et al. (1988) reported that actual or attempted intercourse, compared with genital touching, was associated with higher scores on the Present State Examination (PSE), a measure of current mental health.

The available evidence suggests a number of conclusions. As noted earlier, ratings of trauma or lasting harm are not the same as indices of adjustment or psychopathology. These concepts are likely to be related, but they are not equivalent. Trauma or harm are personal and subjective, whereas adjustment or symptomatology are usually tied to some external anchor and tend to be objective. In those studies where abuse involving penetration was adequately frequent, the results support an association between invasive sexual abuse and trauma or harm. Where the outcome measure was adjustment, mental health status, or other psychiatric symptoms, the results are suggestive but not certain.

Other relevant variables known for their traumatic effects, such as the use of force or threat of force or abuse involving a father or stepfather, are all likely to be correlated with invasiveness, so that the independent effect of abuse involving penetration remains suggestive but still elusive.

Family Functioning

Individuals with a history of CSA are more likely than nonabused controls to originate from single-parent families or families with a high level of marital conflict (Bryer et al., 1987). In addition, these families are generally characterized by psychopathology in the form of depression, substance abuse, and violence among parents and siblings (Bell et al., 1981; Bliss, 1984; Coons & Milstein, 1986; Russell, 1986; Silbert & Pines, 1981). Multiple regression analysis has been used to examine the contribution of family variables to the outcome of sexually abused children. Conte and Schuerman (1987) found that variables indicating the presence of supportive relationships and the general functioning of the victim's family together explained the largest amount of variance in both social worker-completed measures and parent-completed measures of child function. Similarly, Peters (1988) found the quality of maternal warmth to be the strongest predictor of psychological difficulty in adulthood, accounting for 25% of the variance, although sexual abuse accounted for additional variance. These findings again highlight the potential mediating factors that may interact with CSA in determining adult outcome.

CONCLUSION

Behavioral research involving clinical samples or population surveys usually hopes to delineate associations among predictor and outcome variables. Because individual variables tend to have multiple correlates, it is often difficult to establish which pair of correlations best

reflects the underlying phenomenon. Inferences about the relation between two variables can only be certain when other correlated variables are appropriately controlled. Although very few of the studies reviewed here were able to achieve the controls required, recurring themes are sufficiently evident to permit some conclusions about the long-term effects of CSA.

1. In comparison with women not reporting a history of CSA, women who do report a history of CSA more commonly:
 - show evidence of sexual disturbance or dysfunction;
 - report homosexual experiences in adolescence or adulthood;
 - show evidence of anxiety and fear, which may be related to force or threat of force during the abuse;
 - show evidence of depression and depressive symptomatology;
 - show evidence of revictimization experiences;
 - show evidence of suicidal ideas and behavior, particularly when they have been exposed to force or violence.
2. Insufficient evidence exists to show a relationship between a history of CSA and:
 - a postsexual abuse syndrome;
 - personality disorders such as MPD and BPD; however, MPD may be associated with a history of both sexual and physical abuse.
3. When the relationship between abuse-specific variables and particular outcomes is examined, the following conclusions may be drawn:
 - the relationship between age of onset of abuse and outcome remains unclear, although more evidence exists to support a more traumatic impact of postpubertal abuse than prepubertal abuse;
 - long duration of abuse is associated with greater impact;
 - the use of force or threat of force is associated with negative outcome; the specific long-term effects are not yet known;
 - abuse involving penetration (intercourse or oral-genital sex) is associated with greater long-term harm;
 - abuse involving a father or stepfather is associated with greater long-term harm;
 - male victims of CSA appear to show disturbance of adult sexual functioning.

The role of family variables, such as marital conflict and parental psychopathology, are thought to have a pivotal impact on the child's response to the abuse and on the long-term outcome. The evidence suggests that parental attitudes towards the child and toward the child's role in the event are important determinants of the long-term impact of CSA. The child's interpretation of the experience and the child's perception of the mother's response to the child and to the abuse may also be important. The long-term impact of the timing, circumstances, and manner of disclosure are not known and may be a fruitful area for further research.

The exact number of women sexually abused as children is not known since the rates vary from 6% to 62% (Finkelhor, 1987); however, it is clear that sexual abuse is a widespread and important problem with serious long-term sequelae. To what extent the sequelae are due to sex abuse per se is still not known. Clearly, those children subjected to CSA are commonly revictimized in numerous ways, all of which contribute to the long-term impact. A clearer delineation of the effects of abuse-specific variables may offer opportunities for more focused interventions.

Also possible is the generation of specific hypotheses about the various effects of CSA in relation to certain outcomes, such as the importance of the combination of sex abuse and force in predicting MPD or suicidality. To advance our understanding of the effects of CSA,

the next generation of studies will have to be more focused and hypothesis-driven. With our current state of knowledge this is not only possible but expected.

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Résumé—La littérature en cours sur les séquelles à long terme des sévices sexuels à l'égard des enfants est passée en revue. L'évidence suggère que l'abus sexuel est un problème évident avec de graves séquelles à long terme, mais les effets spécifiques liés à l'abus sexuel, indépendamment du recours à la force ou de la menace du recours à la force ou des variables familiales, telle que la psychopathologie parentale doivent encore être clarifiés. Les femmes adultes qui ont été victimes de sévices sexuels au cours de leur enfance présentent des signes de troubles sexuels, elles rapportent des expériences homosexuelles à l'adolescence ou à l'âge adulte, elles présentent des symptômes dépressifs et courent plus de risques d'être victimisées à nouveau. L'anxiété, la peur, les idées et le comportement suicidaires ont également été associés avec des antécédents d'abus sexuel au cours de l'enfance mais le recours à la force et la menace du recours à la force sont probablement des aspects concomitants nécessaires. L'état actuel des connaissances ne permet pas de confirmer la relation entre l'existence d'antécédents d'abus sexuel au cours de l'enfance et le développement d'un syndrome post-abus sexuel ou de troubles de la personnalité de type "état limite." Les victimes masculines d'abus sexuel au cours de l'enfance présentent un fonctionnement sexuel adulte perturbé. La relation entre l'âge lors des premiers sévices sexuels et le pronostic est encore équivoque. Des troubles graves à long terme sont associés à l'abus impliquant le père ou le beau-père et à l'abus impliquant la pénétration. Une longue durée des abus est associée

avec un impact plus grand et l'utilisation de la contrainte ou la menace du recours à la force sont associés avec des troubles plus graves. Des suggestions pour de futures recherches sont discutées.

Resumen—Se revisa la literatura existente sobre las secuelas a largo plazo del abuso sexual contra los niños. La evidencia sugiere que el abuso sexual es un problema importante con secuelas serias a largo plazo pero los efectos específicos del abuso sexual, independientes de la fuerza, amenazas de violencia o variables familiares como psicopatología de los padres, todavía no han sido clarificadas. Las mujeres adultas con una historia de abuso sexual en la infancia muestran evidencias de perturbaciones sexuales o disfunción, reportan experiencias homosexuales en la adolescencia o la adultez, muestran evidencias de depresión y tienen más probabilidad de ser revictimizadas, que las no abusadas. Ansiedad, miedo y acciones e ideas suicidas han sido también asociadas a una historia de abuso sexual en la infancia pero la fuerza o amenazas del uso de la fuerza podrían ser necesarios concomitantemente. Hasta ahora, no hay suficiente evidencia para confirmar una relación entre la historia de abuso sexual en la infancia y el síndrome de post-abuso sexual y un desorden de personalidad fronteriza o múltiple. Las víctimas masculinas de abuso sexual en la infancia muestran funcionamiento sexual adulto perturbado. La relación entre la edad en que ocurre el abuso y las consecuencias son todavía equívocas. Se asocia un daño con mayor permanencia en el abuso donde está incluido el padre o padrastro y el abuso que incluye penetración. Larga duración se asocia con mayor impacto y el uso de la fuerza o amenazas del uso de la fuerza se asocian con mayor daño. Se discuten algunas sugerencias para futuras investigaciones.